APPROVED

BOARD OF DENTISTRY

MINUTES
SPECIAL CONFERENCE COMMITTEE "B"

TIME AND PLACE: Special Conference Committee "B" convened on March 14, 2008, at 9:09 a.m., at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, VA 23233.

APPROVAL OF MINUTES: Ms. Sissom moved to approve the minutes of the Special Conference Committee "B" meeting held on January 25, 2008. The motion was seconded and passed.

FIRST CONFERENCE:

PRESIDING: Edward P. Snyder, D.D.S.

MEMBERS PRESENT: Darryl J. Pirok, D.D.S.
Misty L. Sissom, R.D.H.

STAFF PRESENT: Alan Heaberlin, Deputy Director
Cheri Emma-Leigh, Operations Manager
Gail W. Ross, Adjudication Specialist

QUORUM: All three members of the Committee were present.

MURR R. OETTINGER, D.D.S.
Case Nos. 108094, 108095, 99372 and 104949

Murr R. Oettinger, D.D.S., appeared without counsel to discuss allegations that he may have violated laws and regulations governing the practice of dentistry, in that,

1. On multiple occasions in 2006, he prescribed Schedule VI controlled substances to the following patients in violation of Term #1 of the Board's Order entered September 28, 2005, prohibiting such acts:

    a. From on or about February 14, 2006 to April 26, 2006, he prescribed erythromycin as a pre-treatment antibiotic to Patient A on four (4) occasions.

    b. On or about February 14, 2006, he prescribed erythromycin as a pre-treatment

antibiotic to Patient B.

c. On or about February 16, 2006, he prescribed cephalexin as a pre-treatment antibiotic to Patient C.

d. In addition, on or about February 27, 2006, he prescribed cephalexin as a pre-treatment antibiotic to Patient D.

e. In or about March 2006, he prescribed penicillin as a pre-treatment antibiotic to Patient E.

f. In or about March 2006, he prescribed penicillin as a pre-treatment antibiotic to Patient G.

g. In or about April 2006, he prescribed penicillin as a pre-treatment antibiotic to Patient H.

h. On or about March 10, 2006, he prescribed amoxicillin as a pre-treatment antibiotic to Patient F.

i. On or about April 27, 2006, he prescribed ketoconzaole as a pre-treatment antibiotic to Patient I.

2. During an inspection of his office on April 25, 2006, pursuant to Term #2 of the Board's Order entered September 28, 2005:

   a. Schedule VI medications were located in his office, which was contrary to Term #1 of the Board's Order, in that he was prohibited from possessing any controlled substances.

   b. The inspector submitted a photograph of a counter in his operatory that had an unclean face mask and water bottle, which demonstrated lack of proper sanitation in the treatment area.

3. Following an inspection of Dr. Oettinger's office on April 12, 2007, by the Department of Health Professions' inspector, he failed to submit his two hundred dollar ($200) inspection fee within thirty (30) days of the inspection, in accordance with the Board's Order entered September 28, 2005.

4. There was no updated health history in Patient A's record, which showed treatment from 1990 to 2006.

5. On or about February 14, 2006, he failed to document in Patient A and B's chart that he prescribed erythromycin prior to treatment.

6. By his own admission, in or about April 1997, he billed Patient J's insurance company for treatment of tooth #12 rather than tooth #13, which was actually treated.

7. He changed the treatment date in Patient K's chart from November 20, 2002 to December 21, 2002, in order to obtain payment from the insurance company.

8. He fraudulently billed insurance companies for initial examinations of existing patients. Specifically, Patient O was his patient since 1999, and on or about October 6, 2000, May 16, 2001, and February 23, 2003, he billed her insurance company for initial examinations. In addition, Patient P was his patient since 2001, and on or about February 22, 2002, he billed his insurance company for an initial examination. Further, Patient L was his patient since 1990, and on or about January 23, 1999 and March 4, 2000, he billed her insurance company for initial examinations.

9. In or about February 2002, he received payment in the amount of $110.40 from Patient N's insurance company for treatment that totaled $138.00. He fraudulently billed Patient N for the total payment of

$138.00, claiming that the insurance company denied the claim.

10. From January 16, 2001 through September 6, 2001, he and/or his staff issued receipts for cash payments received from patients Q-V, but failed to record said payments in his daily ledger.

11. On February 26, 2003, he and/or his staff issued a receipt to Patient M for a cash payment of $225.00, but recorded in his daily ledger that he received $120.00.

12. In or about January 2005, during his treatment of Patient W, he failed to diagnose periodontal disease.

13. In or about 2002, he failed to diagnose extensive caries while treating Patient X.

14. In or about 2005, he failed to diagnose and treat multiple sites of decay found on Patient Y and Z's teeth.

15. The records for Patients A-Z were poorly documented. Specifically, the recorded diagnosis for all patients was minimal, and in many instances totally absent.

The Committee received Dr. Oettinger's statements and discussed the evidence in the case with him.

The Committee received statements from Astrid E. Oettinger on behalf of Dr. Oettinger.

The Committee received statements from Richard Wilson, D.D.S. and Loretta Hopson-Bush, Compliance Case Manager, on behalf of the Commonwealth of Virginia.

Closed Meeting:

Ms. Sissom moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(28) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of Murr R. Oettinger, D.D.S. Additionally, Ms. Sissom moved that Board staff, Alan Heaberlin and Cheri

Emma-Leigh, and Administrative Proceedings Division staff, Gail Ross, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene: Ms. Sissom moved to certify that only matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Committee. The motion was seconded and passed.

The Committee reconvened in open session pursuant to § 2.2-3712(D) of the Code.

DECISION: Ms. Ross reported that the Committee decided to refer the matter to the Board for a Formal Hearing and to simultaneously offer a Consent Order for the surrender of Dr. Oettinger's license to practice dentistry in the Commonwealth of Virginia. Dr. Pirok moved to adopt the Committee's decision as reported by Ms. Ross. The motion was seconded and passed.

SECOND CONFERENCE: 1:05 P.M.

PRESIDING: Edward P. Snyder, D.D.S.

MEMBERS PRESENT: Darryl J. Pirok, D.D.S.
Misty L. Sissom, R.D.H.

STAFF PRESENT: Alan Heaberlin, Deputy Director
Cheri Emma-Leigh, Operations Manager
Gail W. Ross, Adjudication Specialist

QUORUM: All three members of the Committee were present.

GEORGE A. OLEY, III, D.D.S.
Case Nos. 110378, 105511 and 111229

George A. Oley, III, D.D.S., appeared with counsel, Gerald C. Canaan, II, Esq., to discuss allegations that he may have violated laws and regulations governing the practice of dentistry, in that,

1. On or about July 12, 2006, he completed a root canal and core build-up on tooth #19 without administering anesthetic to Patient A, who

experienced extreme pain during the procedure.

2. In or about 2004, he placed a bridge and crowns on teeth #22 through #28, and performed a core build-up on tooth #23, despite the fact that Patient B had severe gum inflammation and gum disease below the gum line, which he failed to diagnose and treat and/or refer for periodontal treatment.

3. In or about 2004, he failed to inform Patient B of her condition when she presented to him with severe gum inflammation and gum disease below the gum line or refer her to another dentist for treatment of said condition.

4. From in or about April 2004 to August 2004, he failed to properly diagnose and treat caries for Patient C on teeth #14 and #15 before placing a three-unit bridge on teeth #13, #14 and #15.

5. In or about June and July 2004, Patient A's chart failed to include the diagnosis for which treatment was rendered when he delivered a crown on teeth #14 and #20. Further, in June and July 2006, Patient A's chart failed to include the diagnosis when he performed a root canal on tooth #19.

6. In or about 2004 to 2006, he failed to consistently record a list of drugs administered or dispensed, and the quantity used during Patient B and C's restorative work. In addition, on or about July 12, 2006, he failed to document Patient A's record when he allegedly administered Lidocaine with epinephrine into the canal of tooth #19 during treatment to complete a root canal and core build-up.

7. In or about July 2006, he failed to retain an x-ray in Patient A's chart, which was taken following completion of a root canal on tooth #19.

8. In or about 2004, he failed to include a date on Patient C's panoramic x-ray. During that same time, x-rays taken prior to performing root canal therapy on Patient C's teeth #13 and #14 were not retained in the patient record.

9. In or about June and July 2004, he failed to retain a duplicate of laboratory work orders for Patient A's crowns.

10. In or about April and May 2004, he failed to retain a duplicate of laboratory work orders for Patient B's bridge and crowns.

11. From July 2004 to February 2005, he failed to include his complete address on laboratory work orders for Patient C.

The Committee received Dr. Oley's statements and discussed the evidence with him.

The Committee received statements from Christina Whittington, Dental Assistant, on behalf of Dr. Oley.

The Committee received statements from Patient B.

Closed Meeting: Ms. Sissom moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(28) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of George A. Oley, III. Additionally, Ms. Sissom moved that Board staff, Alan Heaberlin and Cheri Emma-Leigh, and Administrative Proceedings Division staff, Gail Ross, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene: Ms. Sissom moved to certify that only matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Committee. The motion was seconded and passed.

The Committee reconvened in open session pursuant to § 2.2-3712(D) of the Code.

DECISION: Ms. Ross read the Findings of Fact and Conclusions of Law as adopted by the Committee as follows:

1. Dr. Oley holds a current Virginia dental license.

2. Dr. Oley violated § 54.1-2706(9) of the Code and 18 VAC 60-20-15(4) of the Regulations, in that, in or about 2004 to 2006, he failed to consistently record a list of drugs administered or dispensed, and the quantity used during Patient B's restorative work. Further, Dr. Oley provided evidence that on March 5, 2008, he and his staff were presented and passed a test on the Board's Power Point Presentation, "Recordkeeping – Beyond the Regulatory Requirement," located on the Board's website.

Ms. Ross reported that no sanctions will be imposed.

Ms. Sissom moved to adopt the Findings of Fact, Conclusions of Law and Sanctions imposed. The motion was seconded and passed.

As provided by law, this decision shall become a Final Order thirty days after service of such on Dr. Oley unless a written request to the Board for a formal hearing on the allegations made against him is received from Dr. Oley. If service of the Order is made by mail, three additional days shall be added to that period. Upon such timely request for a formal hearing, the decision of the Committee shall be vacated.

THIRD CONFERENCE: 3:44 p.m.

PRESIDING: Edward P. Snyder, D.D.S.

MEMBERS PRESENT: Darryl J. Pirok, D.D.S.
Misty L. Sissom, R.D.H.

STAFF PRESENT: Alan Heaberlin, Deputy Director
Cheri Emma-Leigh, Operations Manager
Julia Bennett, Adjudication Specialist

OTHERS PRESENT: James Schliessmann, Assistant Attorney General

QUORUM: All three members of the Committee were present.

Virginia Board of Dentistry
Special Conference Committee "B"
March 14, 2008

GREGORY P. LYNNE, D.D.S.
Case No. 114178

Gregory P. Lynne, D.D.S., appeared with counsel, Marc Baron, Esq., to discuss allegations that he may have violated laws and regulations governing the practice of dentistry warranting the summary restriction, in that,

1. On or about April 5, 2006, his supervising dentist observed him performing an extraction on a patient's lower left first molar by first cleanly breaking off the crown, which was intact with minimal decay, and then laying a periosteal flap down to the apex of the roots, followed by removal of the alveolar bone with a bone bur until buccal bone was removed down to the root tips. This method of extraction was consistent with extractions witnessed by other staff members, who observed him to routinely extract teeth by fracturing off the crown with forceps and then digging out the remaining tooth. Said method of extraction produces greater than necessary tissue disruption, causing or increasing the likelihood of subsequent infection. Even though his supervisor advised him to discontinue breaking off crowns during extraction procedures, he continued to do so. Subsequently, on or about May 11, 2006, his supervisor suspended his oral surgery privileges until he completed an approved continuing education class in oral surgery; however, he failed to take such class, and, on or about March 9, 2007, he was terminated from his position due to this and other matters.

2. Staff members frequently observed or noted that he failed to prescribe necessary antibiotics and appropriate pain medications to patients following dental procedures. For example:

    a. On or about October 12, 2005, he extracted tooth #32 of Patient A, but failed to write a prescription for antibiotics and prescribed only Ibuprofen 600 mg for pain. Subsequently, on or about October 26, 2005, Patient A presented to him complaining of continued pain, and he removed spicules of bone at the prior

extraction site. Again, he failed to prescribe any antibiotic after this procedure and only prescribed Ibuprofen for pain. On October 29, 2005, Patient A was admitted to the hospital complaining of difficulty swallowing, fever, pain and swelling inside and in the floor of his mouth, and swelling in his neck glands. Patient A was diagnosed with dental infection and cervical cellulitis, administered antibiotics, and discharged on October 31, 2005. Patient A's symptoms continued and, on November 1, 2005, he was admitted to the hospital's intensive care unit with a diagnosis of Ludwig's angina/parapharyngeal space infection with abscess probable post-operative infection. On November 3, 2005, an incision and drainage of the abscess on Patient A's neck was performed, and the patient was discharged on November 6, 2005.

b. On or about April 25, 2006, he extracted teeth #14, #16, and #17-#19 of Patient B, but failed to write a prescription for antibiotics and prescribed only Ibuprofen 800 mg for pain. On April 30, 2006, a physician at the facility prescribed amoxicillin to Patient B. On May 1, 2006, Patient B presented with complaints of swelling of the throat, difficulty swallowing and breathing, a low-grade fever, a lump in his throat and also under his left lateral jaw on the neck, and limited ability to open his mouth. Dr. Lynne's response was to prescribe Patient B Tylenol #3. He did not refer Patient B to the emergency room for treatment until the next day, at which time he also prescribed clindamycin. The emergency room physician diagnosed Patient B with peritonsillar cellulitis and uvulitis, noting the possibility that the dental extraction could have created the soft tissue infection and by proxy gotten the uvula involved. Patient B was treated with

antibiotics, prescribed pain medications, and discharged. On May 10, 2006, Patient B was re-admitted to the emergency room with complaints of trismus, dysphagia, and odynophagia with otalgia. A CT scan revealed an acute left peritonsillar abscess, which was incised and drained.

3. Staff members frequently observed or noted that Dr. Lynne failed to administer adequate anesthesia to patients prior to and during dental procedures. For example, on or about February 1, 2007, he was ready to commence incision and drainage of a fistula next to Patient C's tooth #13 without administering anesthesia, and did so only at the insistence of the nurse assisting him. Further, he did not initially prescribe antibiotics for Patient C after completion of the procedure until questioned by the dental assistant about the need to do so.

4. During the 2005-2006 time period, multiple staff members observed him falling asleep during the performance of dental procedures on patients.

5. On or about February 21, 2007, while preparing to seat the first patient of the day for treatment, he engaged in threatening and disruptive behavior when, at nose-to-nose closeness, he accused his dental assistant of making "back biting" statements and physically forced her to back up from the clinic area into the lab area by his menacing forward motion. This event, among other things, led to termination of his job at the Department of Corrections, which was subsequently upheld at an employment grievance hearing held on or about September 6, 2007.

The Committee received Dr. Lynne's statements and discussed the evidence in the case with him.

The Committee received statements from Christine Goodman, Dental Assistant and Linda Defibaugh, Dental Assistant. The Committee received statements from

George A. Smith, D.D.S. by telephone conference call.
Mr. Schliessmann summarized the statements of Linda Huestis, RN, and Dana Vandevander as presented in the investigative report and stated that they were present and available for questioning by the Committee.

Ms. Sissom moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(28) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of Gregory P. Lynne, D.D.S.. Additionally, Ms. Sissom moved that Board staff, Alan Heaberlin and Cheri Emma-Leigh, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene: Ms. Sissom moved to certify that only matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Committee. The motion was seconded and passed.

The Committee reconvened in open session pursuant to § 2.2-3712(D) of the Code.

DECISION: Dr. Snyder reported that the Committee decided to refer the matter to the Board for a Formal Hearing. Ms. Sissom moved to adopt the decision of the Committee. The motion was seconded and passed.

ADJOURNMENT: With all business concluded, the Committee adjourned at 7:34 p.m..

Edward P. Snyder, Chair

Sandra K. Reen, Executive Director

Date

Date